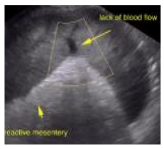
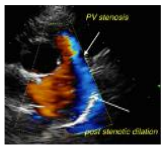
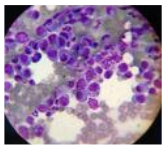
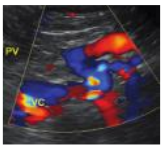
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Roxy Christian

SPECIES
Feline

BREED
DMH

SEX
Spayed Female

AGE
16 Years

WEIGHT
6.07 Pounds

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Harmon

HOSPITAL NAME
Willamette VH

REFERRING VET
Dr. Harmon

INVOICE
37720

DATE
5/18/22

PRESENTING CLINICAL SIGNS

Transfer from RDVM for hosp for renal dz. Recently pt had four teeth removed and was eating wet food, pt really wanted dry food and was happy, pt stopped eating dry food and wasnt interested in wet food either, this began about a week ago. Pt has been straining to have BM, last night more straining and nothing was produced. Pt ahs been PU/PD, O noticed back legs have been wobbly and pt cant get into LB by herself. O thinks last good meal was most likely over a week ago poss two weeks. pt has hx of overeating and then V+, no other issues that O knows of. No V+ out of the ordinary per O, pt did V+ last night while pt was straining to have a BM, was salivating and then V+. No D+ noted
Abnormal PE/Chem/CBC/UA Results: CBC: RBC 5.68, HCT 22.2, HGB 7.7, RDW 27.8%, lymp 0.66, eos 0.0, Chem 10: Crea 12.9, BUN >130, ALT 223 Phos: >16.1 EPOC: HCT 23%, Bicarb 11.1, Ca 1.1, Crea 12.15, Glu 151, Na 144, lac 3.27, pH 7.118, po2 59.5, tco2 11.6, BUN >120, so2 81.1
AFAST: Left kidney rounded 3 cm width with normal corticomedullary definition and no evidence of pylectasia, right kidney 1cm length and 0.5-1 cm width with no normal architecture, biliary ducts appear widened, stomach empty, bladder moderately full with normal echogenicity, no free fluid noted
ECG/cardiology report: ASSESSMENT: Runs of focal atrial tachycardia, which may be due to the systemic condition (+++ azotemia and electrolyte disturbances) but also be secondary to an undiagnosed underlying condition. The rhythm is not fatal but can cause hemodynamic compromise because of the relatively frequent and fast rate, so medical management could be considered. No radiographic evidence of cardiomegaly or congestive heart failure. Consider that thoracic radiographs are not the most sensitive test to detect chamber enlargement or hypertrophy in cats and as such an underlying cardiomyopathy cannot be fully ruled out when cardiomegaly is not radiographically present. RECOMMENDATIONS: There is no evidence of congestive heart failure and as such there is no strict contraindication for IVFT, above all in light of the severe dehydration and azotemia, however there is a risk for pushing the patient into CHF. Recommend monitoring RR as per submitted notes (q2 hr) and reduce/discontinue IV if concerned for tachypnea. The arrhythmia may be indeed due to uremic/azotemia damage to the heart and could be transient,so you could consider to keep monitoring the rhythm and consider treatment if this results in a hemodynamically unstable patient/ hypotension is observed. The rate is fast but not excessive, and as such monitoring could be a reasonable option.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

The **kidneys** were swollen with minor pyelectasia noted. Subnormal blood flow on color flow assessment. The right kidney was severely dystrophic, vestigial at 1.8 cm. Complete lack of blood flow on color assessment.

Adrenal Glands

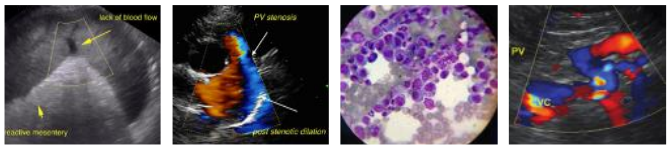
The **adrenal glands** were unremarkable.

Spleen

The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not



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clinically significant at this time. Multifocal biliary mineralization noted, non-obstructive. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

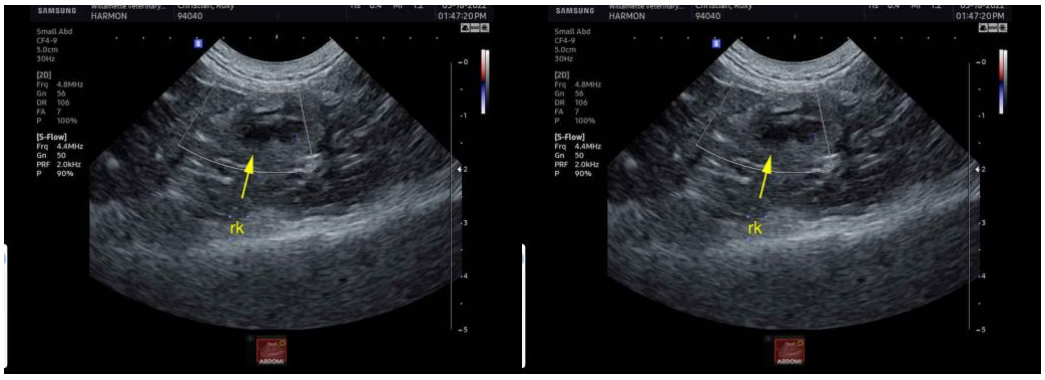
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- Chronic degenerative renal disease - Dystrophic non-functional right kidney and moderate degenerative left renal changes with pyelectasia and swelling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

72-hour IV fluid protocol recommended. Management of acute on chronic renal failure and blood pressure measurements recommended. Prognosis is guarded. No evidence or suspicion of neoplasia. Urine culture warranted if any inflammatory sediment is present. However, the right kidney appears end stage. The left kidney appears approximately 50% compromised.



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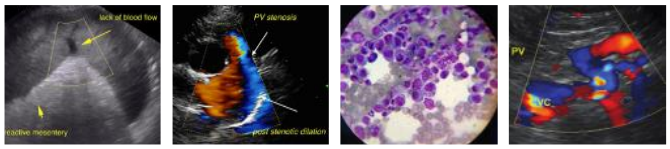

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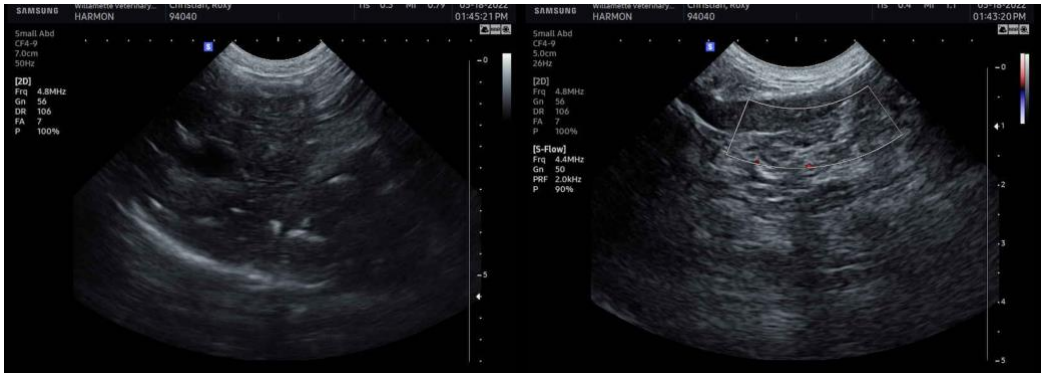

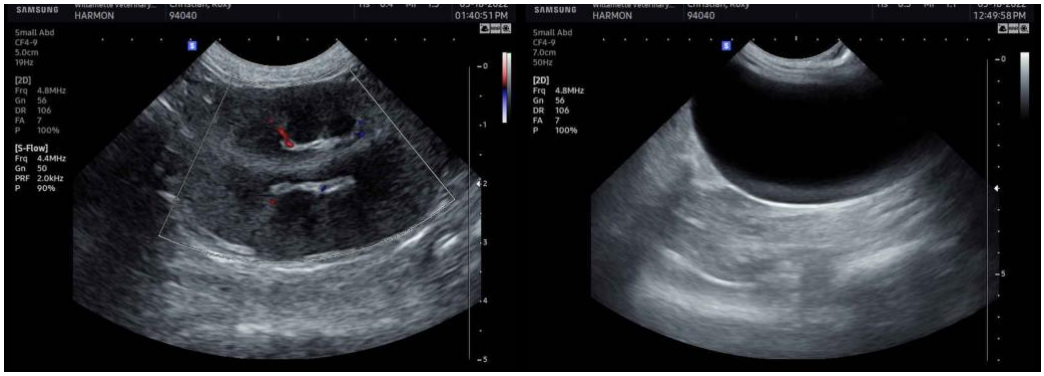

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com